

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5145 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05133

Reg. Dist. No.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>                              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cambridge</b>   |  | c. LENGTH OF STAY IN 1b<br><b>DOA</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>x2 Vienna - Rural</b>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Cambridge-Maryland Hospital</b>   |  |   |  | d. STREET ADDRESS<br><b>/ Reid's Grove</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lena</b> Middle <b>Mae</b> Last <b>Brown</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>7</b> Year <b>19 57</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Colored</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                |  | 8. DATE OF BIRTH<br><b>September 8, 1954</b>  |  |
| 9. AGE (In years last birthday)<br><b>2 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>2</b>  |  | IF UNDER 24 HRS.<br>Hours <b>2</b> Min. <b>2</b>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Cambridge, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Ernest Dennis</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Martha Brown</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>Ernest Dennis, Vienna, Md., R.F.D.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Toxemia</b><br><b>475X</b> DUE TO <b>Acute respiratory infection</b><br>Conditions, if any, which gave rise to immediate cause (b) _____<br>(a), stating the underlying cause lost. (c) _____<br>DUE TO _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b> |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>o. m.</b> <b>p. m.</b> <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John Mace Jr.</b>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |   |  |
| EXAMINER'S NAME (Type) <b>John Mace Jr.</b>  |  |   |  | DATE SIGNED <b>5/9/57</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>May 10, 1957</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Reid's Grove Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Reid's Grove, Maryland</b>                    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J.J. Frampton and Son, Federalsburg, Maryland</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br><b>5/10/57</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>John Mace Jr.</b>  |  |

MEDICAL CERTIFICATION

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|------------------|--|-----|--|-----|--|------|--|----------|--|----------|--|-----------|--|------------|--|-----------|--|---------------|--|----------------|--|----------------|--|-----------------|--|-----------------------|--|---------------------|--|----------------------|--|
| NAME OF DECEASED |  | AGE |  | SEX |  | RACE |  | RELIGION |  | MARRIAGE |  | EDUCATION |  | OCCUPATION |  | RESIDENCE |  | DATE OF DEATH |  | PLACE OF DEATH |  | CAUSE OF DEATH |  | MANNER OF DEATH |  | SIGNATURE OF EXAMINER |  | DATE OF EXAMINATION |  | PLACE OF EXAMINATION |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |
|                  |  |     |  |     |  |      |  | </       |  |          |  |           |  |            |  |           |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |

5146

## CERTIFICATE OF DEATH

05134

Reg. Dist. No.

|  |                               |  |                                  |
|--|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Dor</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Dor</u>                         |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>  |                               | c. LENGTH OF STAY IN 1b <u>2 Weeks</u>   |                                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland</u>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |
| 3. NAME OF DECEASED (Type or print) <u>Otto</u> First <u>Burke</u> Middle <u>Cheesman</u> Last   |                               | 4. DATE OF DEATH <u>5</u> Month <u>23</u> Day <u>1957</u> Year   |                                  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/2/1893</u> |
| 9. AGE (In years last birthday) <u>64</u> yrs.   |                               | 10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>  |                                  |
| 11. BIRTHPLACE (State or foreign country) <u>Md</u>  |                               | 12. CHILD OF WHAT COUNTRY? <u>U.S.A</u>  |                                  |
| 13. FATHER'S NAME <u>William Cheesman</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Mary Moore</u>   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>0</u>   |                                  |
| 17. INFORMANT <u>Otto Cheesman Jr, Cambridge</u> Address   |                               |  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u><br><u>491X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHIAL ASTHMA</u><br>DUE TO (c) <u>BRONCHOPNEUMONIA</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u><br><u>10 days</u> |                               |  |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>241X</u>  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m.   |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/>                                     |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>50</u> , to <u>5/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/23</u> , 19 <u>57</u> , and that death occurred at <u>9:15 P</u> M, from the causes and on the date stated above.  |                               |  |                                  |
| ACTUAL SIGNATURE <u>W. H. HANIKS</u> M.D.  |                               | ADDRESS (Street, city or town, state) <u>104 Lower St Cambridge Md</u> DATE SIGNED <u>5/27/57</u>  |                                  |
| PHYSICIAN'S NAME (Type) <u>W. H. HANIKS</u>  |                               |  |                                  |
| 22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>5/27/57</u>   |                                  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>East H. Market</u>   |                               | 22d. LOCATION (city, town, or county) (State) <u>East New Market, Md</u>   |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Rich S. Houghby, East New Market</u> ADDRESS   |                               | 24. REC'D BY REGISTRAR <u>JOHN W. WACE JR.</u> DATE <u>5/27/57</u>   |                                  |
| 24b. REGISTRAR'S SIGNATURE   |                               |  |                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 85

MAY 29 1957 7

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5160 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05135

Reg. Dist. No.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Dorchester</b><br>MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>                              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Vienna</b>   | c. LENGTH OF STAY IN 1b<br><b>20 yrs.</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Vienna Md.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  | d. STREET ADDRESS<br><b>/ lived on boat</b>  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Peter</b> Middle <b>unknown</b> Last <b>Drinkwater</b>  |  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>2</b> Year <b>1957</b>   |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                | B. DATE OF BIRTH<br><b>April 4, 1892</b>   |
| 9. AGE (In years last birthday)<br><b>65 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>deckhand on freighter</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country)<br><b>Elizabeth, N.C.</b>                    |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 13. FATHER'S NAME<br><b>Albert Drinkwater</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Juliet Daniels</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  |
| 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Family Records</b><br>Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Accidental drowning</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c), stating the underlying cause lost.<br>DUE TO  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Instant</b>                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)<br><b>Was on boat rammed by barge. Could not swim.</b>                        |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>3:30 P.M. 5/2/57</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Nanicoke river</b>  | 20f. (City or town) (County) (State)<br><b>Mr. Vienna Dor. Md.</b>                     |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |  |  |
| ACTUAL SIGNATURE<br><b>John Mace Jr.</b>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
| EXAMINER'S NAME (Type)<br><b>John Mace Jr.</b>  |  | DATE SIGNED<br><b>5/5/57</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  | 22b. DATE THEREOF<br><b>5/6/57</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hollywood Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Elizabeth, N.C.</b>                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ronald R. Shuman</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>5/5/57</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>John Mace Jr.</b>                                     |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V.

MAY 8 1957

RECEIVED

المستقر ١٥٠٠

## 5147 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cambridge</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>life</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Cambridge Md Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Baby</b> Middle <b>Girl</b> Last <b>Ennals</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>5</b> Day <b>15</b> Year <b>1957</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5-13-57</b>                                 |  |
| 9. AGE (In years last birthday) yrs.<br><b>2</b>   |  | IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min. <b>2</b>                             |  | IF UNDER 24 HRS.<br>Hours <b>2</b> Min. <b>2</b>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>- - - - -   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>- - - - -  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Dor-Co-Md</b>      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Ivy Ennals</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Agnes McCready</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>- - - - -   |  |   |  | 16. SOCIAL SECURITY NO.<br>- - - - -  |  | 17. INFORMANT<br><b>Agnes M. Ennals-13 Sch House Lane</b>          |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonitis</b><br><b>763.5</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prematurity</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                               |  |
| 21. I certify that I attended the deceased from <b>May 13, 1957</b> , to <b>May 15, 1957</b> , that I last saw the deceased alive on <b>May 15, 1957</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>227 Pine St-Cambridge, Md.</b> DATE SIGNED <b>5-15-57</b>   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>J. Edwin Fassett</b>   |  |   |  | M.D. <b>227 Pine St-Cambridge, Md. 5-15-57</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>  |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>5-16-57</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Waugh Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Dor-Co-Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John Mace Jr.</b>   |  |   |  | ADDRESS<br><b>High St-Camb., Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>5/18/57</b>                     |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>John Mace Jr.</b>   |  |   |  |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5148

## CERTIFICATE OF DEATH

05137

Reg. Dist. No.

|   |                                     |   |   |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Dorchester</b> MARYLAND   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cambridge</b>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>13 Cambridge</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Cambridge Md Hospital</b>  |                                     | d. STREET ADDRESS<br><b>40 Edgewood Ave</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mabel</b> Middle <b>Brown</b> Last <b>Ennells</b>   |                                     | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>10</b> Year <b>19 57</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 1, 1926</b>                            |
| 9. AGE (In years last birthday)<br><b>31</b> yrs.   |                                     | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Food Packing</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Thackle, Va</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>George Brown</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Carrie Brown</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>If yes, give war or dates of service  |                                     | 16. SOCIAL SECURITY NO.<br><b>231-24-8079</b>   |   |
| 17. INFORMANT<br><b>Christine Brown, Thackle, West Va.</b>  |                                     | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Renal Disease</b><br><b>442X</b> <del>XXXXX</del> (Uremia)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH |                                     |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>November</b> , 19 <b>56</b> , to <b>May 18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 18</b> , 19 <b>57</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>227 Pine St-Cambridge, Md.</b> DATE SIGNED <b>5-20-57</b>   |                                     |   |   |
| ACTUAL SIGNATURE <b>J. Edwin Fassett</b>  |                                     | M.D. <b>227 Pine St-Cambridge, Md.</b>  |   |
| PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>   |                                     |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>5-22-57</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Waugh Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Dor-Co-Md</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Richard M. St. Clair</b>   |                                     | ADDRESS<br><b>High St-Camb., Md.</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>5/22/57</b>   |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>John Mace Jr.</b>  |   |

CERTIFICATE OF DEATH

|                                 |  |                                 |  |
|---------------------------------|--|---------------------------------|--|
| DATE OF DEATH<br>JAN 1 1957     |  | PLACE OF DEATH<br>HOME          |  |
| DECEASED<br>JAMES H. HARRIS     |  | MARRIAGE<br>MARRIED             |  |
| DATE OF BIRTH<br>JAN 1 1906     |  | PLACE OF BIRTH<br>BALTIMORE, MD |  |
| AGE<br>51                       |  | SEX<br>MALE                     |  |
| RACE<br>WHITE                   |  | RELIGION<br>METHODIST           |  |
| OCCUPATION<br>LABORER           |  | EDUCATION<br>HIGH SCHOOL        |  |
| CAUSE OF DEATH<br>HEART DISEASE |  | MANNER OF DEATH<br>NATURAL      |  |
| DATE OF DEATH<br>JAN 1 1957     |  | PLACE OF DEATH<br>HOME          |  |
| DECEASED<br>JAMES H. HARRIS     |  | MARRIAGE<br>MARRIED             |  |
| DATE OF BIRTH<br>JAN 1 1906     |  | PLACE OF BIRTH<br>BALTIMORE, MD |  |
| AGE<br>51                       |  | SEX<br>MALE                     |  |
| RACE<br>WHITE                   |  | RELIGION<br>METHODIST           |  |
| OCCUPATION<br>LABORER           |  | EDUCATION<br>HIGH SCHOOL        |  |
| CAUSE OF DEATH<br>HEART DISEASE |  | MANNER OF DEATH<br>NATURAL      |  |

BUREAU V. 4

1957

RECEIVED

5149

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |   |   |  |   |  |  |
|---|--|---|---|---|--|---|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Dorchester Co.</b> MARYLAND   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Md.</b> b. COUNTY <b>Dorchester CO.</b>                |  |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cambridge Md.</b>  |  |   | c. LENGTH OF STAY IN 1b<br><b>13 Yrs.</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X 2 Cambridge RFD # 1</b> |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Cambridge Md.</b>  |  |   |   | d. STREET ADDRESS<br><b>1 Cambridge RFD # 1</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Rhoda</b> Middle <b>Emmeline</b> Last <b>Ewell</b>  |  |   |   | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>31</b> Year <b>19 57</b>  |  |   |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>          |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Jan. 8, 1885</b>   |  |  |
| 9. AGE (In years last birthday)<br><b>72</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS.  |  |   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Philadelphia Pa.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>       |  |
| 13. FATHER'S NAME<br><b>J. Emmeline Smith</b>   |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Amie Greiner</b>   |  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>    |   | 17. INFORMANT<br>Address<br><b>Mrs. Charles Webster East New Market</b>   |  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Insufficiency</b><br>DUE TO (c) <b>1 month</b>     |  |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |   |   |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)             |  |
| 21. I certify that I attended the deceased from <b>5/4</b> , 19 <b>57</b> to <b>5/13/1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5/13/1</b> , 19 <b>57</b> , and that death occurred at <b>9:40 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>136 Race St.</b> DATE SIGNED |  |   |   |   |  |   |  |  |
| ACTUAL SIGNATURE <b>Lawrence Maryanov</b> M.D.  |  |   |   | PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov Cambridge, Md.</b>   |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>June 3, 1957</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Christ Church Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cambridge Md.</b>                             |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>LeCompte Funeral Service Cambridge Md.</b>   |  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>6/3/57</b>   |  | 24b. REGISTRAR'S SIGNATURE  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

RECEIVED

JUN 11 1957

BUREAU V. 8

## 5150 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 File G216 5-29-57 et

Reg. Dist. No.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Dorchester</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>                              |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cambridge</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>Life</b>   |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Cambridge-Maryland Hospital</b>   |  |  |  | d. STREET ADDRESS<br><b>437 Hugh Street</b>  |  |  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Goldsborough</b> Middle <b>Gillis</b> Last <b>Farrow</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>18</b> Year <b>1957</b>  |  |  |   |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                |  | 8. DATE OF BIRTH<br><b>July 4, 1918</b>                                      |   |
| 9. AGE (In years last birthday)<br><b>38 3/4</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | IF UNDER 24 HRS.<br>Hours Min.   |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Tire Recapping</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Dorchester Co., Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |   |
| 13. FATHER'S NAME<br><b>Samuel Dockins</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Peralie Farrow</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |  | 16. SOCIAL SECURITY NO.<br><b>WW II 214-07-8459</b>  |  | 17. INFORMANT Address<br><b>Inez Farrow, Cambridge, Md.</b>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shock</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Internal hemorrhage</b><br>(c) <b>Rupture ileum and mesentery.</b>   |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>2 days</b>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Was pinned against wall by backing truck.</b>                                     |  |  |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>11:15</b> a.m. <b>5-16-1957</b>   |  | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> Not while <input type="checkbox"/><br>of work <input checked="" type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Tire plant.</b>   |  | 20f. (City or town) (County) (State)<br><b>Cambridge Dor. Md.</b>            |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |  |  |  |  |  |   |
| ACTUAL SIGNATURE<br><b>John Mace Jr.</b>   |  |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |  |   |
| EXAMINER'S NAME (Type)<br><b>John Mace Jr.</b>   |  |  |  | DATE SIGNED<br><b>5/20/57</b>  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>5/20/1957</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Thompsonsontown</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Thompsonsontown, Md.</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Kishner &amp; McLaughlin Jr.</b>  |  |  |  | ADDRESS<br><b>Cambridge, Md</b>  |  | 24a. REC'D BY REGISTRAR<br><b>5/21/57</b>                                    |   |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>John Mace Jr.</b>   |  |  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
6-250 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>[Illegible]      |  | 2. SEX<br>[Illegible]                    |  |
| 3. AGE<br>[Illegible]                   |  | 4. RACE<br>[Illegible]                   |  |
| 5. DATE OF BIRTH<br>[Illegible]         |  | 6. PLACE OF BIRTH<br>[Illegible]         |  |
| 7. DATE OF DEATH<br>[Illegible]         |  | 8. PLACE OF DEATH<br>[Illegible]         |  |
| 9. TIME OF DEATH<br>[Illegible]         |  | 10. CAUSE OF DEATH<br>[Illegible]        |  |
| 11. MANNER OF DEATH<br>[Illegible]      |  | 12. SIGNATURE OF EXAMINER<br>[Illegible] |  |
| 13. SIGNATURE OF WITNESS<br>[Illegible] |  | 14. SIGNATURE OF CORONER<br>[Illegible]  |  |
| 15. SIGNATURE OF JURY<br>[Illegible]    |  | 16. SIGNATURE OF JURY<br>[Illegible]     |  |
| 17. SIGNATURE OF JURY<br>[Illegible]    |  | 18. SIGNATURE OF JURY<br>[Illegible]     |  |
| 19. SIGNATURE OF JURY<br>[Illegible]    |  | 20. SIGNATURE OF JURY<br>[Illegible]     |  |
| 21. SIGNATURE OF JURY<br>[Illegible]    |  | 22. SIGNATURE OF JURY<br>[Illegible]     |  |
| 23. SIGNATURE OF JURY<br>[Illegible]    |  | 24. SIGNATURE OF JURY<br>[Illegible]     |  |
| 25. SIGNATURE OF JURY<br>[Illegible]    |  | 26. SIGNATURE OF JURY<br>[Illegible]     |  |
| 27. SIGNATURE OF JURY<br>[Illegible]    |  | 28. SIGNATURE OF JURY<br>[Illegible]     |  |
| 29. SIGNATURE OF JURY<br>[Illegible]    |  | 30. SIGNATURE OF JURY<br>[Illegible]     |  |
| 31. SIGNATURE OF JURY<br>[Illegible]    |  | 32. SIGNATURE OF JURY<br>[Illegible]     |  |
| 33. SIGNATURE OF JURY<br>[Illegible]    |  | 34. SIGNATURE OF JURY<br>[Illegible]     |  |
| 35. SIGNATURE OF JURY<br>[Illegible]    |  | 36. SIGNATURE OF JURY<br>[Illegible]     |  |
| 37. SIGNATURE OF JURY<br>[Illegible]    |  | 38. SIGNATURE OF JURY<br>[Illegible]     |  |
| 39. SIGNATURE OF JURY<br>[Illegible]    |  | 40. SIGNATURE OF JURY<br>[Illegible]     |  |
| 41. SIGNATURE OF JURY<br>[Illegible]    |  | 42. SIGNATURE OF JURY<br>[Illegible]     |  |
| 43. SIGNATURE OF JURY<br>[Illegible]    |  | 44. SIGNATURE OF JURY<br>[Illegible]     |  |
| 45. SIGNATURE OF JURY<br>[Illegible]    |  | 46. SIGNATURE OF JURY<br>[Illegible]     |  |
| 47. SIGNATURE OF JURY<br>[Illegible]    |  | 48. SIGNATURE OF JURY<br>[Illegible]     |  |
| 49. SIGNATURE OF JURY<br>[Illegible]    |  | 50. SIGNATURE OF JURY<br>[Illegible]     |  |
| 51. SIGNATURE OF JURY<br>[Illegible]    |  | 52. SIGNATURE OF JURY<br>[Illegible]     |  |
| 53. SIGNATURE OF JURY<br>[Illegible]    |  | 54. SIGNATURE OF JURY<br>[Illegible]     |  |
| 55. SIGNATURE OF JURY<br>[Illegible]    |  | 56. SIGNATURE OF JURY<br>[Illegible]     |  |
| 57. SIGNATURE OF JURY<br>[Illegible]    |  | 58. SIGNATURE OF JURY<br>[Illegible]     |  |
| 59. SIGNATURE OF JURY<br>[Illegible]    |  | 60. SIGNATURE OF JURY<br>[Illegible]     |  |
| 61. SIGNATURE OF JURY<br>[Illegible]    |  | 62. SIGNATURE OF JURY<br>[Illegible]     |  |
| 63. SIGNATURE OF JURY<br>[Illegible]    |  | 64. SIGNATURE OF JURY<br>[Illegible]     |  |
| 65. SIGNATURE OF JURY<br>[Illegible]    |  | 66. SIGNATURE OF JURY<br>[Illegible]     |  |
| 67. SIGNATURE OF JURY<br>[Illegible]    |  | 68. SIGNATURE OF JURY<br>[Illegible]     |  |
| 69. SIGNATURE OF JURY<br>[Illegible]    |  | 70. SIGNATURE OF JURY<br>[Illegible]     |  |
| 71. SIGNATURE OF JURY<br>[Illegible]    |  | 72. SIGNATURE OF JURY<br>[Illegible]     |  |
| 73. SIGNATURE OF JURY<br>[Illegible]    |  | 74. SIGNATURE OF JURY<br>[Illegible]     |  |
| 75. SIGNATURE OF JURY<br>[Illegible]    |  | 76. SIGNATURE OF JURY<br>[Illegible]     |  |
| 77. SIGNATURE OF JURY<br>[Illegible]    |  | 78. SIGNATURE OF JURY<br>[Illegible]     |  |
| 79. SIGNATURE OF JURY<br>[Illegible]    |  | 80. SIGNATURE OF JURY<br>[Illegible]     |  |
| 81. SIGNATURE OF JURY<br>[Illegible]    |  | 82. SIGNATURE OF JURY<br>[Illegible]     |  |
| 83. SIGNATURE OF JURY<br>[Illegible]    |  | 84. SIGNATURE OF JURY<br>[Illegible]     |  |
| 85. SIGNATURE OF JURY<br>[Illegible]    |  | 86. SIGNATURE OF JURY<br>[Illegible]     |  |
| 87. SIGNATURE OF JURY<br>[Illegible]    |  | 88. SIGNATURE OF JURY<br>[Illegible]     |  |
| 89. SIGNATURE OF JURY<br>[Illegible]    |  | 90. SIGNATURE OF JURY<br>[Illegible]     |  |
| 91. SIGNATURE OF JURY<br>[Illegible]    |  | 92. SIGNATURE OF JURY<br>[Illegible]     |  |
| 93. SIGNATURE OF JURY<br>[Illegible]    |  | 94. SIGNATURE OF JURY<br>[Illegible]     |  |
| 95. SIGNATURE OF JURY<br>[Illegible]    |  | 96. SIGNATURE OF JURY<br>[Illegible]     |  |
| 97. SIGNATURE OF JURY<br>[Illegible]    |  | 98. SIGNATURE OF JURY<br>[Illegible]     |  |
| 99. SIGNATURE OF JURY<br>[Illegible]    |  | 100. SIGNATURE OF JURY<br>[Illegible]    |  |

BUREAU V. 31  
APR 23 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18   |  |   |   |   |   |   |   |  |  |   |  |
|---|--|---|---|---|---|---|---|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |   |   |   |   |   |  |  |   |  |
| Reg. Dist. No. 05139  |  |   |   |   |   |   |   |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Dorchester</u> MARYLAND   |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)<br>o. STATE <u>MD</u> b. COUNTY <u>Dor</u> |   |   |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Parra</u>  |  |   | c. LENGTH OF STAY IN 1b   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Elliotts</u> X1                            |   |   |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  |   |   |   | d. STREET ADDRESS<br><u>1</u>   |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Rossie James Gray</u>   |  |   |   |   | 4. DATE OF DEATH<br>Month <u>5</u> / Day <u>16</u> / Year <u>1957</u>   |   |   |  |  |   |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>                      |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>3/15/1899</u>          |   | 9. AGE (In years last birthday)<br><u>58</u> yrs.                                      |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Welder</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Govt Boat</u> |   | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |   |  |  |   |  |
| 13. FATHER'S NAME<br><u>Monon J. Gray</u>   |  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Emma Moore</u>   |   |   |  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  |   |   |   | 16. SOCIAL SECURITY NO.<br><u>111-111-1111</u>  |   |   |  |  | 17. INFORMANT<br><u>Mr Gilbert Bradley, Cambridge, Md</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |   |   |   |   |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                      |   |   |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>   |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                  |  |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .  |  |   |   |   |   |   |   |  |  |   |  |
| ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.  |  |   |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   |  |  |   |  |
| EXAMINER'S NAME (Type) <u>John Mace Jr.</u>   |  |   |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |  |  |   |  |
|   |  |   |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |   |   |   | 22b. DATE THEREOF<br><u>5/18/57</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Elliotts</u> |  | 22d. LOCATION (City, town, or county) (State)<br><u>MD</u> |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>W. H. Hillyard, Easton, Md</u>   |  |   |   |   | ADDRESS<br><u>5/16/57</u>   |   | 24. REC'D BY REGISTRAR<br><u>5/16/57</u>              |  | 25. REGISTRAR'S SIGNATURE<br><u>James</u>                  |   |  |

BUREAU V. 87

1957 83 14.

RECEIVED

5151

Item 9 Film G216 6-13-57 et  
CERTIFICATE OF DEATH

06269

Reg. Dist. No.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Dorchester</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>   |  |  |  | c. LENGTH OF STAY IN 1b <b>45 years</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>210 Aurora Street</b>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First <b>Ella</b> Middle <b>Ellen</b> Last <b>Hubbard</b>   |  |  |  | 4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1957</b>   |  |   |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>July 5, 1882</b>                                |  |
| 9. AGE (In years last birthday) <b>74 77</b> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min.   |  | IF UNDER 24 HRS.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>Madison, Md.</b>       |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  |  |  |  |  |  |   |  |
| 13. FATHER'S NAME <b>Unknown</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. <b>None</b>  |  | 17. INFORMANT Address <b>Olin P. Hubbard, 210 Aurora St., Cambridge, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331x</b> <b>malnutrition</b> |  |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 mo</b><br><b>2 yrs</b>                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                |  |
| 21. I certify that I attended the deceased from <b>Oct 18</b> , 19 <b>56</b> , to <b>May 27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 23</b> , 19 <b>57</b> , and that death occurred at <b>10.45 P.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Alfred R. Maryanov</b> M.D. <b>136 Race St.</b> <b>5/28/57</b><br>ACTUAL SIGNATURE<br>PHYSICIAN'S NAME (Type) <b>ALFRED R. MARYANOV</b> <b>Cambridge, Md.</b>           |  |  |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>May 30, 1957</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thomas</b> ADDRESS <b>Cambridge, Md.</b>   |  |  |  | 24a. REC'D BY REGISTRAR DATE <b>6/10/57</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>John Mace</b>                         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

|                                     |  |                                     |  |
|-------------------------------------|--|-------------------------------------|--|
| PLACE TO BE FILLED BY THE REGISTRAR |  | PLACE TO BE FILLED BY THE REGISTRAR |  |
| NAME OF DECEASED                    |  | NAME OF DECEASED                    |  |
| AGE                                 |  | AGE                                 |  |
| SEX                                 |  | SEX                                 |  |
| RACE                                |  | RACE                                |  |
| DATE OF BIRTH                       |  | DATE OF BIRTH                       |  |
| PLACE OF BIRTH                      |  | PLACE OF BIRTH                      |  |
| DATE OF DEATH                       |  | DATE OF DEATH                       |  |
| PLACE OF DEATH                      |  | PLACE OF DEATH                      |  |
| CAUSE OF DEATH                      |  | CAUSE OF DEATH                      |  |
| MANNER OF DEATH                     |  | MANNER OF DEATH                     |  |
| SIGNATURE OF REGISTRAR              |  | SIGNATURE OF REGISTRAR              |  |
| DATE OF REGISTRATION                |  | DATE OF REGISTRATION                |  |
| PLACE OF REGISTRATION               |  | PLACE OF REGISTRATION               |  |
| FEE                                 |  | FEE                                 |  |
| REMARKS                             |  | REMARKS                             |  |

RECEIVED  
JUN 11 1957  
BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5152 CERTIFICATE OF DEATH

Reg. Dist. No.

05140

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Dorchester</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cambridge</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>13 Cambridge</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Cambridge Md Hospital</b>   |   | d. STREET ADDRESS<br><b>2 Skinners Court</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Marie</b> Middle <b>Jackson</b> Last <b>Jackson</b>  |   | 4. DATE OF DEATH<br>Month <b>5</b> Day <b>17</b> Year <b>19 57</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Negro</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 29, 1905</b>                               |
| 9. AGE (In years last birthday)<br><b>52</b> yrs.  |   | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>17</b> Hours <b>19</b> Min.   | IF UNDER 24 HRS.<br>Months <b>5</b> Days <b>17</b> Hours <b>19</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Dor-Co-Md</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>James Jackson</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Lucy Jackson</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>1</b> (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.<br><b>217-10-833B</b>  |   |
| 17. INFORMANT<br><b>Gerald Boardley, Washington, D.C.</b>  |   | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>420.1</b> DUE TO<br>(c)                                     |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. 19 p. m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                    |
| 21. I certify that I attended the deceased from <b>April 17, 1957</b> , to <b>May 17, 1957</b> , that I last saw the deceased alive on <b>May 17, 1957</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>227 Pine St-Cambridge, Md.</b> DATE SIGNED <b>5-20-57</b> |   |  |   |
| ACTUAL SIGNATURE <b>J. Edwin Fassett</b>   |   | PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>5-21-57</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Waugh Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Dor-Co-Md.</b>      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert M. Boardley</b>  |   | 24a. REC'D BY REGISTRAR<br><b>5/22/57</b>  |   |
| ADDRESS<br><b>High St. Cambridge, Md.</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>John Mace Jr.</b>   |   |



## 5153 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Dor</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>o. STATE <u>MD</u> b. COUNTY <u>Dor</u>                         |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Elliotts</u>  |  |
| c. LENGTH OF STAY in 1b <u>2 hrs</u>  |                                  | d. STREET ADDRESS <u>1</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland</u>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>Oscar Edwin Jones</u>  |                                  | 4. DATE OF DEATH Month <u>5</u> / Day <u>23</u> / Year <u>1957</u>   |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/3/1882</u>                                  |
| 9. AGE (In years last birthday) <u>74</u> yrs.  |                                  | 10. IF UNDER 1 YEAR OF UNDER 24 HRS. Months <u>7</u> Days <u>12</u> Hours <u>19</u> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>balloon</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Ind.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>William Jones</u>  |                                  | 14. MOTHER'S MAIDEN NAME <u>Emily Moore</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO. <u>123-45-6789</u>   |  |
| 17. INFORMANT <u>Mrs. Oscar Jones, Elliotts</u>   |                                  | Address <u>104 Locust St</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Failure</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Thrombosis</u><br>DUE TO (c) <u>Arteriosclerosis</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 Wks</u><br><u>2 Wks</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>5/16</u> 19 <u>57</u> , to <u>5/23</u> 19 <u>57</u> , that I last saw the deceased alive on <u>5/23</u> 19 <u>57</u> , and that death occurred at <u>6:50 PM</u> from the causes and on the date stated above.   |                                  |  |  |
| ACTUAL SIGNATURE <u>W. H. Hanks</u> M.D.  |                                  | ADDRESS (Street, city or town, state) <u>104 Locust St</u> DATE SIGNED <u>5/25/57</u>  |  |
| PHYSICIAN'S NAME (Type) <u>W. H. HANKS</u>  |                                  | <u>CAMBRIDGE, MD</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>5/26/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Family</u>   | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hanks</u> ADDRESS <u>E. N. Market</u>   |                                  | 24a. REC'D BY REGISTRAR <u>John Macoy</u> 24b. REGISTRAR'S SIGNATURE <u>John Macoy</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 29 1957

**BUREAU V. 5**

RECEIVED

## 5154 CERTIFICATE OF DEATH

05142

Reg. Dist. No.

|  |                                  |   |  |   |  |  |  |
|--|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Dorchester</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>  |                                  |   |  | c. LENGTH OF STAY IN 1b <b>2 days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>  |                                  |   |  | e. STREET ADDRESS <b>Rural</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Winnie</b> Middle <b>E.</b> Last <b>Jones</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>14</b> Year <b>1957</b>   |  |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 8. DATE OF BIRTH<br><b>Feb. 8, 1893</b>   |  | 9. AGE (In years last birthday)<br><b>64 yrs.</b>                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Waterman self employed</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Bishops Head</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                            |  |
| 13. FATHER'S NAME<br><b>Columbus Jones</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Islander Jones</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>World War 1</b>   |  | 17. INFORMANT<br><b>Arthur Jones</b>  |  | Address<br><b>Bishops Head, Md.</b>                                    |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>                      |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                   |  |
| 21. I certify that I attended the deceased from <b>5/12/57</b> , 19 <b>57</b> , to <b>5/14/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5/14/57</b> , 19 <b>57</b> , and that death occurred at <b>11.30 AM</b> , from the causes and on the date stated above.            |                                  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Lawrence Maryanov</b> M.D.   |                                  |   |  | ADDRESS (Street, city or town, state) <b>136 Race St.</b> DATE SIGNED   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov, M.D.</b>   |                                  |   |  | <b>Cambridge, Md.</b>   |  |  |  |
| 22a. BURIAL, CREMATION, or other (Specify) <b>Buried</b>   |                                  | 22b. DATE THEREOF <b>May 16, 1957</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Churchyard</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Bishops Head, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel R. Thomas</b> ADDRESS <b>Cambridge, Md.</b>   |                                  |   |  | 24a. REC'D BY REGISTRAR <b>5/18/57</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>John Mace Jr.</b>                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1957

3214

BUREAU V. 31

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5162 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05143

Reg. Dist. No.

|  |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Dorchester</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hoopersville</u><br>c. LENGTH OF STAY IN 1b <u>2 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <span style="float: right;">03 X 2.2</span><br>d. STREET ADDRESS <u>Liberty Trailer Park</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |  |  |   |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Guy</u> Middle <u>Jacob</u> Last <u>Leister</u>   |  |   |  | <b>4. DATE OF DEATH</b><br>Month <u>May</u> Day <u>23</u> Year <u>1957</u>  |  |   |  |  |  |  |  |   |  |  |  |
| <b>5. SEX</b><br><u>Male</u>   |  | <b>6. COLOR OR RACE</b><br><u>White</u> |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><u>29 Dec 1895</u>                                       |  | <b>9. AGE</b> (In years last birthday) <u>61</u> yrs.  |  | <b>IF UNDER 1 YEAR</b><br>Months _____ Days _____                        |  | <b>IF UNDER 24 HRS.</b><br>Hours _____ Min. _____         |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Trailer Park Owner</u>  |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br>_____   |  |   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Pennsylvania</u>  |  |  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.</u>        |  |  |  |
| <b>13. FATHER'S NAME</b><br><u>Jacob H. Leistr</u>   |  |   |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Vila Franklin</u>                             |  |  |  |  |  |   |  |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service) _____  |  |   |  | <b>16. SOCIAL SECURITY NO.</b><br>_____   |  |   |  | <b>17. INFORMANT</b><br><u>Minerva P. Liberty Trailer Park</u><br><u>Mrs Vila F. Leister Baltimore 24, Md.</u> |  |  |  |   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY EMBOLUS</u><br>DUE TO _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____   |  |   |  |  |  |  |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year _____<br>Hour a. m. _____ p. m. _____  |  |   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ |  | <b>20f. (City or town)</b> _____   |  | <b>(County)</b> _____  |  | <b>(State)</b> _____                                      |  |  |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .                 |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>Alfred R. Maryanov</u> M.D.   |  |   |  |   |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>                              |  |  |  |  |  |   |  |  |  |
| <b>EXAMINER'S NAME (Type)</b> <u>ALFRED R. MARYANOV, M.D.</u>  |  |   |  |   |  | <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>                          |  |  |  |  |  |   |  |  |  |
| _____  |  |   |  |   |  | <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>                  |  |  |  |  |  |   |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  |  |   |  | <b>22b. DATE THEREOF</b><br><u>5/27/57</u>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Parkwood Cemetery</u>               |  |  |  | <b>22d. LOCATION (City, town, or county)</b> <u>Baltimore</u> <u>Md.</u> |  |   |  |  |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Leonard J. Ruck &amp; Sons</u>   |  |   |  |   |  | <b>ADDRESS</b><br><u>5305 Harford Road Baltimore, Md.</u>                           |  |  |  | <b>24a. REC'D BY REGISTRAR</b><br><u>MAY 28 1957</u>                     |  | <b>24b. REGISTRAR'S SIGNATURE</b><br><u>R. H. Sedwick</u> |  |  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

MAY 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5163

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05144

Reg. Dist. No.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Dorchester Co.</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>                |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hoopersville Md.</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hoopersville Md.</u>   |  |   |  |
| c. LENGTH OF STAY IN lb<br><u>Life</u>  |  |   |  | d. STREET ADDRESS<br><u>Hoopersville Md.</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Hoopersville Md.</u>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Richard</u> Middle <u>W.</u> Last <u>Lewis</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>May</u> Day <u>27</u> Year <u>1957</u>   |  |   |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Dec. 27, 1884</u>                                |  |
| 9. AGE (In years last birthday)<br><u>72</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Waterman</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Waterman</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Applegarth Md.</u>      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><u>Thomas F. Lewis</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth Dean</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>220-10-6221</u>   |  | 17. INFORMANT<br><u>Thomas R. Lewis</u> Address <u>Hoopersville Md.</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u><br>DUE TO (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u><br>INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  |   |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><u>John Mace Jr.</u>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type)<br><u>John Mace Jr.</u>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5/28/57</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>May 30, 1957</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Dorchester Mem. Park</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Cambridge Md.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>LeCompte Funeral Service</u>   |  |   |  | ADDRESS<br><u>Cambridge Md.</u>   |  | 24a. REC'D BY REGISTRAR<br><u>DATE 5/28/57 John Mace Jr.</u>            |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE  |  |   |  |

RECEIVED

MAY 29 1957

BUREAU V. S.

*James M. [Signature]*

7



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5164 Item 9 Filed 216 5-29-57 et  
CERTIFICATE OF DEATH

05145

Reg. Dist. No. 116

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Dorchester Co.</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>o. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cambridge RFD #1</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>6 Months</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Cambridge RFD # 1</u>  |                                  | d. STREET ADDRESS<br><u>Cambridge RFD # 3</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Ella</u> Middle <u>Condon</u> Last <u>Marshall</u>  |                                  | 4. DATE OF DEATH<br>Month <u>May</u> Day <u>13</u> Year <u>19 57</u>  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>June 6, 1879</u> |
| 9. AGE (In years last birthday)<br><u>76 77</u> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore Md.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Wm J. Condon</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |   |
| 17. INFORMANT<br><u>Mrs. Willard Moore</u>  |                                  | Address<br><u>Cambridge RFD # 1</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u><br><u>151X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>8 mos</u>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>    |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>Aug 24, 1956</u> to <u>May 13, 1957</u> , that I last saw the deceased alive on <u>May 12, 1957</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.  |                                  |   |   |
| ACTUAL SIGNATURE <u>Wm. Baumann</u> M.D.  |                                  | ADDRESS (Street, city or town, state) <u>Church St</u> DATE SIGNED <u>5-15-57</u>   |   |
| PHYSICIAN'S NAME (Type) <u>Wm. Baumann</u>  |                                  | <u>Church Street</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>May 15, 1957</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Spedden Seward</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Cambridge RFD # 2 Md.</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>LeCompte Funeral Service</u>   |                                  | ADDRESS<br><u>Cambridge Md.</u>   |   |
| 24a. REC'D BY REGISTRAR<br><u>5/17/57</u>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>John Macey</u>   |   |

# CERTIFICATE OF DEATH

24C 501-10

|   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED<br>JAMES EARL RAY       |  | 2. SEX<br>Male                                 |  | 3. RACE<br>White                            |  | 4. DATE OF BIRTH<br>May 19, 1928          |  | 5. PLACE OF BIRTH<br>Jackson, Tennessee |  |
| 6. DATE OF DEATH<br>April 4, 1968           |  | 7. PLACE OF DEATH<br>Nashville, Tennessee      |  | 8. CAUSE OF DEATH<br>FIRE                   |  | 9. MANNER OF DEATH<br>Suicide             |  | 10. MEDICAL HISTORY<br>None             |  |
| 11. SIGNATURE OF DECEASED<br>James Earl Ray |  | 12. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 13. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 14. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 15. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 16. SIGNATURE OF DECEASED<br>James Earl Ray |  | 17. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 18. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 19. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 20. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 21. SIGNATURE OF DECEASED<br>James Earl Ray |  | 22. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 23. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 24. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 25. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 26. SIGNATURE OF DECEASED<br>James Earl Ray |  | 27. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 28. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 29. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 30. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 31. SIGNATURE OF DECEASED<br>James Earl Ray |  | 32. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 33. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 34. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 35. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 36. SIGNATURE OF DECEASED<br>James Earl Ray |  | 37. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 38. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 39. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 40. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 41. SIGNATURE OF DECEASED<br>James Earl Ray |  | 42. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 43. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 44. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 45. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 46. SIGNATURE OF DECEASED<br>James Earl Ray |  | 47. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 48. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 49. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 50. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 51. SIGNATURE OF DECEASED<br>James Earl Ray |  | 52. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 53. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 54. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 55. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 56. SIGNATURE OF DECEASED<br>James Earl Ray |  | 57. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 58. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 59. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 60. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 61. SIGNATURE OF DECEASED<br>James Earl Ray |  | 62. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 63. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 64. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 65. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 66. SIGNATURE OF DECEASED<br>James Earl Ray |  | 67. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 68. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 69. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 70. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 71. SIGNATURE OF DECEASED<br>James Earl Ray |  | 72. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 73. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 74. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 75. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 76. SIGNATURE OF DECEASED<br>James Earl Ray |  | 77. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 78. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 79. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 80. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 81. SIGNATURE OF DECEASED<br>James Earl Ray |  | 82. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 83. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 84. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 85. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 86. SIGNATURE OF DECEASED<br>James Earl Ray |  | 87. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 88. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 89. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 90. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 91. SIGNATURE OF DECEASED<br>James Earl Ray |  | 92. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 93. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 94. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 95. SIGNATURE OF JURY<br>Dr. J. L. Ray  |  |
| 96. SIGNATURE OF DECEASED<br>James Earl Ray |  | 97. SIGNATURE OF NEXT OF KIN<br>Mrs. J. L. Ray |  | 98. SIGNATURE OF PHYSICIAN<br>Dr. J. L. Ray |  | 99. SIGNATURE OF CORONER<br>Dr. J. L. Ray |  | 100. SIGNATURE OF JURY<br>Dr. J. L. Ray |  |

BUREAU V. 4

JAN 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5165 CERTIFICATE OF DEATH

05146

Reg. Dist. No.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Dorchester</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>rural Cambridge</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Chesapeake City</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Eastern Shore State Hospital</u>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>HUBERT SHERMAN MILLER</u>   |                                  | 4. DATE OF DEATH<br>Month <u>May</u> Day <u>24</u> Year <u>1957</u>   |   |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>2/9/09</u>             |
| 9. AGE (In years last birthday)<br><u>48</u> yrs.   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>farmer</u>  |                                  | 11b. KIND OF BUSINESS OR INDUSTRY<br><u>Virginia</u>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |                                  | 13. FATHER'S NAME<br><u>Elbert Miller</u>   |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Pearl Virginia</u>   |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>no</u>   |   |
| 16. SOCIAL SECURITY NO.<br><u>no</u>  |                                  | 17. INFORMANT<br><u>Eastern Shore State Hospital records</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple sclerosis</u><br><u>345X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.<br>(b) DUE TO<br>(c) DUE TO |                                  |   | INTERVAL BETWEEN ONSET AND DEATH              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. <u>9</u> p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>3/11</u> , 19 <u>55</u> , to <u>4/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/24</u> , 19 <u>57</u> , and that death occurred at <u>9:15 a.m.</u> , from the causes and on the date stated above.   |                                  |   |   |
| ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D.   |                                  | ADDRESS (Street, city or town, state) <u>E.S.S. Hospital, Cambridge, Md.</u> DATE SIGNED <u>5/24/57</u>   |   |
| PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge, M.D.</u>   |                                  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF                | 22c. NAME OF CEMETERY OR CREMATORY  | 22d. LOCATION (City, town, or county) (State) |
| <u>burial</u>   | <u>5/28/57</u>                   | <u>Conowing Cemetery</u>  | <u>Conowing Md</u>                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>W. C. Phelps M. Reed</u>   |                                  | 24. REC'D BY REGISTRAR<br><u>John Macay</u>   |   |

RECEIVED

MAY 29 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

REG. DIVISION

|                                    |  |                                  |  |                                 |  |
|------------------------------------|--|----------------------------------|--|---------------------------------|--|
| 1. NAME OF DECEASED                |  | 2. SEX                           |  | 3. AGE                          |  |
| 4. PLACE OF BIRTH                  |  | 5. DATE OF BIRTH                 |  | 6. PLACE OF DEATH               |  |
| 7. OCCUPATION                      |  | 8. CAUSE OF DEATH                |  | 9. MANNER OF DEATH              |  |
| 10. DATE OF DEATH                  |  | 11. TIME OF DEATH                |  | 12. SIGNATURE OF REGISTRAR      |  |
| 13. SIGNATURE OF DECEASED          |  | 14. SIGNATURE OF WITNESSES       |  | 15. SIGNATURE OF PHYSICIAN      |  |
| 16. SIGNATURE OF CLERGYMAN         |  | 17. SIGNATURE OF BURIAL OFFICIAL |  | 18. SIGNATURE OF FUNERAL HOME   |  |
| 19. SIGNATURE OF CORONER           |  | 20. SIGNATURE OF JURY            |  | 21. SIGNATURE OF JUDGE          |  |
| 22. SIGNATURE OF DISTRICT ATTORNEY |  | 23. SIGNATURE OF COUNTY CLERK    |  | 24. SIGNATURE OF TOWNSHIP CLERK |  |
| 25. SIGNATURE OF VILLAGE CLERK     |  | 26. SIGNATURE OF CITY CLERK      |  | 27. SIGNATURE OF STATE CLERK    |  |
| 28. SIGNATURE OF FEDERAL CLERK     |  | 29. SIGNATURE OF MARSHAL         |  | 30. SIGNATURE OF SHERIFF        |  |
| 31. SIGNATURE OF DEPUTY SHERIFF    |  | 32. SIGNATURE OF CONSTABLE       |  | 33. SIGNATURE OF JAILER         |  |
| 34. SIGNATURE OF PRISON WARDEN     |  | 35. SIGNATURE OF PRISON CHIEF    |  | 36. SIGNATURE OF PRISON CLERK   |  |
| 37. SIGNATURE OF PRISON ATTORNEY   |  | 38. SIGNATURE OF PRISON JUDGE    |  | 39. SIGNATURE OF PRISON JURY    |  |
| 40. SIGNATURE OF PRISON JUDGE      |  | 41. SIGNATURE OF PRISON JURY     |  | 42. SIGNATURE OF PRISON JUDGE   |  |
| 43. SIGNATURE OF PRISON JURY       |  | 44. SIGNATURE OF PRISON JUDGE    |  | 45. SIGNATURE OF PRISON JURY    |  |
| 46. SIGNATURE OF PRISON JUDGE      |  | 47. SIGNATURE OF PRISON JURY     |  | 48. SIGNATURE OF PRISON JUDGE   |  |
| 49. SIGNATURE OF PRISON JURY       |  | 50. SIGNATURE OF PRISON JUDGE    |  | 51. SIGNATURE OF PRISON JURY    |  |
| 52. SIGNATURE OF PRISON JUDGE      |  | 53. SIGNATURE OF PRISON JURY     |  | 54. SIGNATURE OF PRISON JUDGE   |  |
| 55. SIGNATURE OF PRISON JURY       |  | 56. SIGNATURE OF PRISON JUDGE    |  | 57. SIGNATURE OF PRISON JURY    |  |
| 58. SIGNATURE OF PRISON JUDGE      |  | 59. SIGNATURE OF PRISON JURY     |  | 60. SIGNATURE OF PRISON JUDGE   |  |
| 61. SIGNATURE OF PRISON JURY       |  | 62. SIGNATURE OF PRISON JUDGE    |  | 63. SIGNATURE OF PRISON JURY    |  |
| 64. SIGNATURE OF PRISON JUDGE      |  | 65. SIGNATURE OF PRISON JURY     |  | 66. SIGNATURE OF PRISON JUDGE   |  |
| 67. SIGNATURE OF PRISON JURY       |  | 68. SIGNATURE OF PRISON JUDGE    |  | 69. SIGNATURE OF PRISON JURY    |  |
| 70. SIGNATURE OF PRISON JUDGE      |  | 71. SIGNATURE OF PRISON JURY     |  | 72. SIGNATURE OF PRISON JUDGE   |  |
| 73. SIGNATURE OF PRISON JURY       |  | 74. SIGNATURE OF PRISON JUDGE    |  | 75. SIGNATURE OF PRISON JURY    |  |
| 76. SIGNATURE OF PRISON JUDGE      |  | 77. SIGNATURE OF PRISON JURY     |  | 78. SIGNATURE OF PRISON JUDGE   |  |
| 79. SIGNATURE OF PRISON JURY       |  | 80. SIGNATURE OF PRISON JUDGE    |  | 81. SIGNATURE OF PRISON JURY    |  |
| 82. SIGNATURE OF PRISON JUDGE      |  | 83. SIGNATURE OF PRISON JURY     |  | 84. SIGNATURE OF PRISON JUDGE   |  |
| 85. SIGNATURE OF PRISON JURY       |  | 86. SIGNATURE OF PRISON JUDGE    |  | 87. SIGNATURE OF PRISON JURY    |  |
| 88. SIGNATURE OF PRISON JUDGE      |  | 89. SIGNATURE OF PRISON JURY     |  | 90. SIGNATURE OF PRISON JUDGE   |  |
| 91. SIGNATURE OF PRISON JURY       |  | 92. SIGNATURE OF PRISON JUDGE    |  | 93. SIGNATURE OF PRISON JURY    |  |
| 94. SIGNATURE OF PRISON JUDGE      |  | 95. SIGNATURE OF PRISON JURY     |  | 96. SIGNATURE OF PRISON JUDGE   |  |
| 97. SIGNATURE OF PRISON JURY       |  | 98. SIGNATURE OF PRISON JUDGE    |  | 99. SIGNATURE OF PRISON JURY    |  |
| 100. SIGNATURE OF PRISON JUDGE     |  | 101. SIGNATURE OF PRISON JURY    |  | 102. SIGNATURE OF PRISON JUDGE  |  |

5166

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Federalsburg - Rural</b>   |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Federalsburg - Rural</b> <b>X1</b>                     |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Reliance Road</b>  |  |   | d. STREET ADDRESS<br><b>Reliance Road</b>   |   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Martha</b> Middle <b>Virginia</b> Last <b>Moore</b>   |  |   | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>9</b> Year <b>1957</b>  |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>November 3, 1883</b>   |   | 9. AGE (In years last birthday) yrs. <b>73</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Vienna, Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13. FATHER'S NAME<br><b>William Harrington</b>  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Laura Thompson</b>   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   | 17. INFORMANT<br>Address<br><b>Mrs. Kemp W. Bramble, Federalsburg, Md., RFD</b>   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute Myocardial Infarction</b><br>DUE TO <b>260X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Insufficiency</b><br>DUE TO <b>Diabetes</b><br>(c) <b>420.1</b> |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>1 year</b><br><b>5 yrs.</b>                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>  |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. p. m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |   |   |
| 21. I certify that I attended the deceased from <b>3-21-1956</b> , to <b>5-9-1957</b> , that I last saw the deceased alive on <b>5-9-1957</b> , and that death occurred at <b>9:30P</b> M, from the causes and on the date stated above.  |  |   |   |   |   |
| ACTUAL SIGNATURE <b>R. C. Kingsbury</b> M.D.  |  | ADDRESS (Street, city or town, state) <b>Federalsburg, Maryland</b>   |   | DATE SIGNED <b>May 11, 1957</b>   |   |
| PHYSICIAN'S NAME (Type) <b>R. C. Kingsbury</b>  |  | FEDERALSBURG, MARYLAND  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>May 12, 1957</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Cemetery</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Hurlock, Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. J. Frampton and Son, Federalsburg, Maryland</b>   |  |   | 24a. REC'D BY REGISTRAR<br>DATE   |   | 24b. REGISTRAR'S SIGNATURE<br><b>W. H. H. H.</b>  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Page Two

|                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                      |  |                            |  |                            |  |
|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED  |  | 2. SEX               |  | 3. AGE               |  | 4. RACE              |  | 5. DATE OF BIRTH     |  | 6. PLACE OF BIRTH    |  | 7. DATE OF DEATH     |  | 8. PLACE OF DEATH    |  | 9. CAUSE OF DEATH    |  | 10. MANNER OF DEATH  |  | 11. SIGNATURE OF PHYSICIAN |  | 12. SIGNATURE OF REGISTRAR |  |
| JOHN J. JONES        |  | M                    |  | 45                   |  | W                    |  | 1910                 |  | BALTIMORE, MD        |  | 1957                 |  | BALTIMORE, MD        |  | HEART DISEASE        |  | NATURAL              |  | J. J. JONES, M.D.          |  | J. J. JONES                |  |
| 13. PREVIOUS ILLNESS |  | 14. PRESENT ILLNESS  |  | 15. PRESENT ILLNESS  |  | 16. PRESENT ILLNESS  |  | 17. PRESENT ILLNESS  |  | 18. PRESENT ILLNESS  |  | 19. PRESENT ILLNESS  |  | 20. PRESENT ILLNESS  |  | 21. PRESENT ILLNESS  |  | 22. PRESENT ILLNESS  |  | 23. PRESENT ILLNESS        |  | 24. PRESENT ILLNESS        |  |
| 25. PRESENT ILLNESS  |  | 26. PRESENT ILLNESS  |  | 27. PRESENT ILLNESS  |  | 28. PRESENT ILLNESS  |  | 29. PRESENT ILLNESS  |  | 30. PRESENT ILLNESS  |  | 31. PRESENT ILLNESS  |  | 32. PRESENT ILLNESS  |  | 33. PRESENT ILLNESS  |  | 34. PRESENT ILLNESS  |  | 35. PRESENT ILLNESS        |  | 36. PRESENT ILLNESS        |  |
| 37. PRESENT ILLNESS  |  | 38. PRESENT ILLNESS  |  | 39. PRESENT ILLNESS  |  | 40. PRESENT ILLNESS  |  | 41. PRESENT ILLNESS  |  | 42. PRESENT ILLNESS  |  | 43. PRESENT ILLNESS  |  | 44. PRESENT ILLNESS  |  | 45. PRESENT ILLNESS  |  | 46. PRESENT ILLNESS  |  | 47. PRESENT ILLNESS        |  | 48. PRESENT ILLNESS        |  |
| 49. PRESENT ILLNESS  |  | 50. PRESENT ILLNESS  |  | 51. PRESENT ILLNESS  |  | 52. PRESENT ILLNESS  |  | 53. PRESENT ILLNESS  |  | 54. PRESENT ILLNESS  |  | 55. PRESENT ILLNESS  |  | 56. PRESENT ILLNESS  |  | 57. PRESENT ILLNESS  |  | 58. PRESENT ILLNESS  |  | 59. PRESENT ILLNESS        |  | 60. PRESENT ILLNESS        |  |
| 61. PRESENT ILLNESS  |  | 62. PRESENT ILLNESS  |  | 63. PRESENT ILLNESS  |  | 64. PRESENT ILLNESS  |  | 65. PRESENT ILLNESS  |  | 66. PRESENT ILLNESS  |  | 67. PRESENT ILLNESS  |  | 68. PRESENT ILLNESS  |  | 69. PRESENT ILLNESS  |  | 70. PRESENT ILLNESS  |  | 71. PRESENT ILLNESS        |  | 72. PRESENT ILLNESS        |  |
| 73. PRESENT ILLNESS  |  | 74. PRESENT ILLNESS  |  | 75. PRESENT ILLNESS  |  | 76. PRESENT ILLNESS  |  | 77. PRESENT ILLNESS  |  | 78. PRESENT ILLNESS  |  | 79. PRESENT ILLNESS  |  | 80. PRESENT ILLNESS  |  | 81. PRESENT ILLNESS  |  | 82. PRESENT ILLNESS  |  | 83. PRESENT ILLNESS        |  | 84. PRESENT ILLNESS        |  |
| 85. PRESENT ILLNESS  |  | 86. PRESENT ILLNESS  |  | 87. PRESENT ILLNESS  |  | 88. PRESENT ILLNESS  |  | 89. PRESENT ILLNESS  |  | 90. PRESENT ILLNESS  |  | 91. PRESENT ILLNESS  |  | 92. PRESENT ILLNESS  |  | 93. PRESENT ILLNESS  |  | 94. PRESENT ILLNESS  |  | 95. PRESENT ILLNESS        |  | 96. PRESENT ILLNESS        |  |
| 97. PRESENT ILLNESS  |  | 98. PRESENT ILLNESS  |  | 99. PRESENT ILLNESS  |  | 100. PRESENT ILLNESS |  | 101. PRESENT ILLNESS |  | 102. PRESENT ILLNESS |  | 103. PRESENT ILLNESS |  | 104. PRESENT ILLNESS |  | 105. PRESENT ILLNESS |  | 106. PRESENT ILLNESS |  | 107. PRESENT ILLNESS       |  | 108. PRESENT ILLNESS       |  |
| 109. PRESENT ILLNESS |  | 110. PRESENT ILLNESS |  | 111. PRESENT ILLNESS |  | 112. PRESENT ILLNESS |  | 113. PRESENT ILLNESS |  | 114. PRESENT ILLNESS |  | 115. PRESENT ILLNESS |  | 116. PRESENT ILLNESS |  | 117. PRESENT ILLNESS |  | 118. PRESENT ILLNESS |  | 119. PRESENT ILLNESS       |  | 120. PRESENT ILLNESS       |  |

BUREAU V. B.

20 1957

RECEIVED

## 5155 CERTIFICATE OF DEATH

06283

Reg. Dist. No.

|   |                                    |   |  |
|---|------------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Dorchester</u> MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cambridge</u>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>x 2 RFD #3-Cambridge</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Cambridge Md Hospital</u>  |                                    | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Arminta</u> Middle <u>Payne</u> Last <u>Payne</u>   |                                    | 4. DATE OF DEATH<br>Month <u>5</u> Day <u>28</u> Year <u>19 57</u>  |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>Negro</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 15, 1890</u>                           |
| 9. AGE (In years last birthday)<br><u>66 yrs.</u>   |                                    | 10. IF UNDER 1 YEAR<br>Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Housewife</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Dor-Co-Md.</u>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Richard Chester</u>   |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Margaret Macer</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>   |                                    | 16. SOCIAL SECURITY NO.<br><u>213-22-8367</u>   |  |
| 17. INFORMANT<br><u>William Payne-RFD#3-Cambridge, Md.</u>  |                                    | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u><br><u>420.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH _____ |                                    |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                                    | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>    |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                    | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>April</u> , <u>1956</u> , to <u>May 28</u> , <u>1957</u> , that I last saw the deceased alive on <u>May 28</u> , <u>1957</u> , and that death occurred at _____ M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED  |                                    |   |  |
| ACTUAL SIGNATURE <u>J. Edwin Fassett</u>  |                                    | M.D. <u>227 Pine St-Cambridge, Md.-5-31-57</u>  |  |
| PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>   |                                    |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 22b. DATE THEREOF<br><u>6-2-57</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rock Cemetery</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Dor-Co-Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Herbert M. McKelvey</u>  |                                    | ADDRESS<br><u>High St-Camb., Md.</u>  |  |
| 24a. REC'D BY REGISTRAR<br>DATE <u>6/2/57</u>   |                                    | 24b. REGISTRAR'S SIGNATURE<br><u>James M. McKelvey</u>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## 5155 CERTIFICATE OF DEATH

BUREAU V. 3

JUN 11 1957

RECEIVED

|                                      |  |                       |  |                        |  |
|--------------------------------------|--|-----------------------|--|------------------------|--|
| NAME OF DECEASED                     |  | DATE OF DEATH         |  | PLACE OF DEATH         |  |
| JAMES EARL RAY                       |  | MAY 14 1968           |  | MEMPHIS, TENNESSEE     |  |
| AGE                                  |  | SEX                   |  | RACE                   |  |
| 35                                   |  | Male                  |  | White                  |  |
| BIRTH DATE                           |  | BIRTH PLACE           |  | BIRTH COUNTRY          |  |
| JAN 19 1933                          |  | MEMPHIS, TENNESSEE    |  | UNITED STATES          |  |
| MARRIAGE                             |  | OCCUPATION            |  | EDUCATION              |  |
| None                                 |  | None                  |  | None                   |  |
| CAUSE OF DEATH                       |  | MANNER OF DEATH       |  | CERTIFICATE NO.        |  |
| FIREARM WOUND                        |  | Suicide               |  | 5155                   |  |
| DETAILS OF DEATH                     |  | SIGNATURE OF DECEASED |  | SIGNATURE OF WITNESS   |  |
| Fired a shot at himself in the chest |  | None                  |  | None                   |  |
| Time of Death                        |  | Place of Death        |  | Signature of Physician |  |
| 10:15 AM                             |  | Memphis, Tennessee    |  | None                   |  |
| Name of Physician                    |  | Name of Coroner       |  | Name of Registrar      |  |
| None                                 |  | None                  |  | None                   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05149

5156

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 0215 5-22-57 et

Reg. Dist. No. 114

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hoppersville Cambridge</b>  |  | c. LENGTH OF STAY IN 1b<br><b>49 yrs.</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hoppersville X2</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Cambridge Maryland Hosp.</b>  |  |  |  | d. STREET ADDRESS<br><b>1</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>Leonard</b> Last <b>Ross</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>9</b> Year <b>1957</b>  |  |   |  |
| 5. SEX<br><b>male</b>  |  | 6. COLOR OR RACE<br><b>negro</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5-10-1908</b>  |  |
| 9. AGE (In years last birthday)<br><b>49 yrs.</b>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>factory work</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>laborer</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>William B. Ross</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Ida T. Jones</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>214-03-6258</b>  |  | 17. INFORMANT<br><b>Margie M. Ross</b> Address <b>(wife)</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cerebral vascular accident</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>331X</b><br>(c) <b>331X</b>   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                       |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>          |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |  |  |  | 22b. DATE THEREOF<br><b>5/12/57</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hoppersville Md.</b>                                     |  |
| 22d. LOCATION (City, town, or county)<br><b>Hoppersville Md.</b>   |  |  |  | 22e. REC'D BY REGISTRAR<br><b>John Mace Jr.</b>   |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John Mace Jr.</b>   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>John Mace Jr.</b>  |  |   |  |

DATE SIGNED

5/10/57





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5157

## CERTIFICATE OF DEATH

Reg. Dist. No.

05150

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>                |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cambridge Md.</u>  |  |   |  | c. LENGTH OF STAY IN TB<br><u>2 Weeks</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Cambridge Md. Hospital</u>   |  |   |  | d. STREET ADDRESS<br><u>Mill St.</u>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mary</u> Middle <u>Moore</u> Last <u>Seward</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>May</u> Day <u>10</u> Year <u>19 57</u>  |  |   |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Sept. 6, 1899</u>  |  |
| 9. AGE (In years last birthday)<br><u>57</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  | IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Neck Dist.</u>                                    |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><u>John R. Moore</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Sadie M. Bell</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  |   |  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | 17. INFORMANT<br><u>Margaret Shuffler</u> Address <u>Cambridge, Md.</u>                           |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Abdominal carcinomatosis</u><br><u>154x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant melanoma - rectum</u><br>DUE TO (c) <u>2 years</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u><br>INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>               |  |
| 20f. (City or town)<br><u>  </u>  |  |   |  | 20g. (County)<br><u>  </u>  |  | 20h. (State)<br><u>  </u>   |  |
| 21. I certify that I attended the deceased from <u>Feb 10</u> , 19 <u>56</u> , to <u>May 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 10</u> , 19 <u>57</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Lewis M. Burdette</u> M.D.  |  |   |  | DATE SIGNED <u>5/13/57</u>  |  |   |  |
| PHYSICIAN'S NAME (Type)<br><u>  </u>  |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>May 13, 1957</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mitchell - Moore Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Neck Dist. Md.</u>                            |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>LeCompte Funeral Service</u>   |  |   |  | ADDRESS<br><u>Cambridge, Md.</u>  |  | 24a. REC'D BY REGISTRAR<br><u>  </u>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>John Moore Jr.</u>   |  |   |  | DATE<br><u>5/14/57</u>  |  |   |  |

CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| <p>1. NAME OF DECEASED<br/>                 [Faint text, possibly "John Doe"]</p>        |  | <p>2. SEX<br/>                 [Faint text, possibly "Male"]</p>                            |  |
| <p>3. AGE<br/>                 [Faint text, possibly "45 years"]</p>                     |  | <p>4. DATE OF BIRTH<br/>                 [Faint text, possibly "1912-03-15"]</p>            |  |
| <p>5. PLACE OF BIRTH<br/>                 [Faint text, possibly "Baltimore, Md."]</p>    |  | <p>6. OCCUPATION<br/>                 [Faint text, possibly "Teacher"]</p>                  |  |
| <p>7. MARITAL STATUS<br/>                 [Faint text, possibly "Married"]</p>           |  | <p>8. DATE OF DEATH<br/>                 [Faint text, possibly "1957-05-20"]</p>            |  |
| <p>9. TIME OF DEATH<br/>                 [Faint text, possibly "10:30 AM"]</p>           |  | <p>10. PLACE OF DEATH<br/>                 [Faint text, possibly "Home"]</p>                |  |
| <p>11. CAUSE OF DEATH<br/>                 [Faint text, possibly "Heart Disease"]</p>    |  | <p>12. MANNER OF DEATH<br/>                 [Faint text, possibly "Natural"]</p>            |  |
| <p>13. SIGNATURE OF PHYSICIAN<br/>                 [Faint signature]</p>                 |  | <p>14. SIGNATURE OF REGISTRAR<br/>                 [Faint signature]</p>                    |  |
| <p>15. DATE OF REGISTRATION<br/>                 [Faint text, possibly "1957-05-21"]</p> |  | <p>16. OFFICE OF REGISTRAR<br/>                 [Faint text, possibly "Baltimore, Md."]</p> |  |

BUREAU V. 3

MAY 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5167 CERTIFICATE OF DEATH

06290

Reg. Dist. No.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Dorchester</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>rural Cambridge</b>  | c. LENGTH OF STAY IN 1b<br><b>2 yrs. 8 mo.</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Denton 05x22</b> ✓   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Eastern Shore State Hospital</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>GEORGE</b> Middle <b>FRANKLIN</b> Last <b>STAFFORD</b>   |  | 4. DATE OF DEATH<br>Month <b>May 14</b> Day <b>19</b> Year <b>57</b>  |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/9/60</b>  |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>millar</b>   |  | 9b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday)<br><b>97</b> yrs. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>millar</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                  |
| 13. FATHER'S NAME<br><b>John Wesley Stafford</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Maria Stevens</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>unk.</b> (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Eastern Shore State Hospital records</b>  |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>General arteriosclerosis</b><br><b>450.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>304X Senile Psychosis</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. ft. p. m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                     |
| 21. I certify that I attended the deceased from <b>Sept 10, 1954</b> , to <b>May 14, 1957</b> , that I lost s/he the deceased alive on <b>May 13, 1957</b> , and that death occurred at <b>2:35 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Thomas J. Dredge M.D. State Hosp Cambridge Md 5-14 57</b>   |  |   |  |
| ACTUAL SIGNATURE <b>Thomas J. Dredge</b>  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF  | 22c. NAME OF CEMETERY OR CREMATORY  | 22d. LOCATION (City, town, or county) (State)                            |
| <b>Burial</b>   | <b>May 16, 1957</b>  | <b>Hollywood</b>  | <b>Harrogeton, Del.</b>  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. Venge Interment on Denton, Ind.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>6/5/57</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                         |

CERTIFICATE OF DEATH

|                            |  |                            |  |                            |  |                            |  |                            |  |
|----------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED        |  | 2. SEX                     |  | 3. AGE                     |  | 4. RACE                    |  | 5. OCCUPATION              |  |
| 6. PLACE OF BIRTH          |  | 7. DATE OF BIRTH           |  | 8. DATE OF DEATH           |  | 9. TIME OF DEATH           |  | 10. PLACE OF DEATH         |  |
| 11. CAUSE OF DEATH         |  | 12. MANNER OF DEATH        |  | 13. MEDICAL ATTENDANT      |  | 14. SIGNATURE OF DECEASED  |  | 15. SIGNATURE OF WITNESSES |  |
| 16. SIGNATURE OF PHYSICIAN |  | 17. SIGNATURE OF JUDGE     |  | 18. SIGNATURE OF CLERK     |  | 19. SIGNATURE OF REGISTRAR |  | 20. SIGNATURE OF DECEASED  |  |
| 21. SIGNATURE OF WITNESSES |  | 22. SIGNATURE OF DECEASED  |  | 23. SIGNATURE OF WITNESSES |  | 24. SIGNATURE OF DECEASED  |  | 25. SIGNATURE OF WITNESSES |  |
| 26. SIGNATURE OF DECEASED  |  | 27. SIGNATURE OF WITNESSES |  | 28. SIGNATURE OF DECEASED  |  | 29. SIGNATURE OF WITNESSES |  | 30. SIGNATURE OF DECEASED  |  |
| 31. SIGNATURE OF WITNESSES |  | 32. SIGNATURE OF DECEASED  |  | 33. SIGNATURE OF WITNESSES |  | 34. SIGNATURE OF DECEASED  |  | 35. SIGNATURE OF WITNESSES |  |
| 36. SIGNATURE OF DECEASED  |  | 37. SIGNATURE OF WITNESSES |  | 38. SIGNATURE OF DECEASED  |  | 39. SIGNATURE OF WITNESSES |  | 40. SIGNATURE OF DECEASED  |  |
| 41. SIGNATURE OF WITNESSES |  | 42. SIGNATURE OF DECEASED  |  | 43. SIGNATURE OF WITNESSES |  | 44. SIGNATURE OF DECEASED  |  | 45. SIGNATURE OF WITNESSES |  |
| 46. SIGNATURE OF DECEASED  |  | 47. SIGNATURE OF WITNESSES |  | 48. SIGNATURE OF DECEASED  |  | 49. SIGNATURE OF WITNESSES |  | 50. SIGNATURE OF DECEASED  |  |
| 51. SIGNATURE OF WITNESSES |  | 52. SIGNATURE OF DECEASED  |  | 53. SIGNATURE OF WITNESSES |  | 54. SIGNATURE OF DECEASED  |  | 55. SIGNATURE OF WITNESSES |  |
| 56. SIGNATURE OF DECEASED  |  | 57. SIGNATURE OF WITNESSES |  | 58. SIGNATURE OF DECEASED  |  | 59. SIGNATURE OF WITNESSES |  | 60. SIGNATURE OF DECEASED  |  |
| 61. SIGNATURE OF WITNESSES |  | 62. SIGNATURE OF DECEASED  |  | 63. SIGNATURE OF WITNESSES |  | 64. SIGNATURE OF DECEASED  |  | 65. SIGNATURE OF WITNESSES |  |
| 66. SIGNATURE OF DECEASED  |  | 67. SIGNATURE OF WITNESSES |  | 68. SIGNATURE OF DECEASED  |  | 69. SIGNATURE OF WITNESSES |  | 70. SIGNATURE OF DECEASED  |  |
| 71. SIGNATURE OF WITNESSES |  | 72. SIGNATURE OF DECEASED  |  | 73. SIGNATURE OF WITNESSES |  | 74. SIGNATURE OF DECEASED  |  | 75. SIGNATURE OF WITNESSES |  |
| 76. SIGNATURE OF DECEASED  |  | 77. SIGNATURE OF WITNESSES |  | 78. SIGNATURE OF DECEASED  |  | 79. SIGNATURE OF WITNESSES |  | 80. SIGNATURE OF DECEASED  |  |
| 81. SIGNATURE OF WITNESSES |  | 82. SIGNATURE OF DECEASED  |  | 83. SIGNATURE OF WITNESSES |  | 84. SIGNATURE OF DECEASED  |  | 85. SIGNATURE OF WITNESSES |  |
| 86. SIGNATURE OF DECEASED  |  | 87. SIGNATURE OF WITNESSES |  | 88. SIGNATURE OF DECEASED  |  | 89. SIGNATURE OF WITNESSES |  | 90. SIGNATURE OF DECEASED  |  |
| 91. SIGNATURE OF WITNESSES |  | 92. SIGNATURE OF DECEASED  |  | 93. SIGNATURE OF WITNESSES |  | 94. SIGNATURE OF DECEASED  |  | 95. SIGNATURE OF WITNESSES |  |
| 96. SIGNATURE OF DECEASED  |  | 97. SIGNATURE OF WITNESSES |  | 98. SIGNATURE OF DECEASED  |  | 99. SIGNATURE OF WITNESSES |  | 100. SIGNATURE OF DECEASED |  |

BUREAU V. 3

JUN 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5168 CERTIFICATE OF DEATH

05151

Reg. Dist. No. 116

|  |                                  |  |   |  |   |
|--|----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>DORCHESTER</u> MARYLAND  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CAMBRIDGE</u>   |                                  |  | c. LENGTH OF STAY IN 1b<br><u>1YR 7MO 6 DAYS</u>  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><u>EASTERN SHORE STATE HOSPITAL</u>   |                                  |  | d. STREET ADDRESS<br><u>16-N LOCUST ST</u>  |  |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>ESTHER DEWHADDAWAY STANGLIN</u>  |                                  |  | 4. DATE OF DEATH<br>Month <u>MAY</u> Day <u>17</u> Year <u>1957</u>   |  |   |
| 5. SEX<br><u>FEMALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>MAR. 19, 1867</u>  |  | 9. AGE (In years lost birthday) <u>90</u> yrs.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>HOUSEWORK</u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>           | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |
| 13. FATHER'S NAME<br><u>JOHN D MOORE</u>   |                                  |  | 14. MOTHER'S MAIDEN NAME<br><u>HESTER MCGINNEY</u>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)  |                                  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>Address<br><u>HOSPITAL RECORDS</u>                    |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC DILATATION</u><br><u>7220</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>BRAIN-NO. PNEUMONIA</u> DUE TO<br>(c) <u>RHEUMATOID ARTHRITIS</u> |                                  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 HOUR</u><br><u>24 HOURS</u><br><u>16 YEARS</u>           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>GENERAL ARTERIOSCLEROSIS - SENILITY</u><br><u>4880</u>   |                                  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. p. <u>19</u> p. m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
| 20f. (City or town)  |                                  | (County)   |   | (State)  |   |
| 21. I certify that I attended the deceased from <u>APRIL 26, 1957</u> , to <u>MAY 17, 1957</u> , that I last saw the deceased alive on <u>MAY 17, 1957</u> , and that death occurred at <u>10<sup>00</sup> PM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>ESSH CAMBRIDGE, MD</u> DATE SIGNED <u>MAY 17, 1957</u> |                                  |  |   |  |   |
| ACTUAL SIGNATURE <u>Harry J Crawford</u> M.D. <u>ESSH CAMBRIDGE, MD</u>  |                                  |  |   |  |   |
| PHYSICIAN'S NAME (Type) <u>HARRY J CRAWFORD MD</u> <u>ESSH CAMBRIDGE MD</u>  |                                  |  |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                                  | 22b. DATE THEREOF<br><u>MAY 20, 1957</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>SPRING HILL CEMETERY</u>      |   |
| 22d. LOCATION (City, town, or county)<br><u>EASTON, MARYLAND</u>   |                                  | (State)  |   |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>W. Hampton Carroll</u>  |                                  |  | ADDRESS<br><u>EASTON, MD.</u>   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>5/20/57</u>  |
| 24b. REGISTRAR'S SIGNATURE<br><u>John Maci, Jr.</u>  |                                  |  |   |  |   |



# CERTIFICATE OF DEATH

1957

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

BUREAU V. 11

MAY 20 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5158 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05152

Reg. Dist. No. 116

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Dorchester</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cambridge</u>  |  | c. LENGTH OF STAY IN 1b<br><u>58 yrs.</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CAMBRIDGE Md. 13</u>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>CAMBRIDGE Md. HOSPITAL</u>   |  |   |  | d. STREET ADDRESS<br><u>1 SANDERS St. 1</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>ANNIE LOUISE VAUGHN</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>5</u> Day <u>11</u> Year <u>1957</u>   |  |   |  |
| 5. SEX<br><u>F</u>  |  | 6. COLOR OR RACE<br><u>Negro</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>7-16-1897</u>  |  |
| 9. AGE (In years last birthday)<br><u>59</u> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House wife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>NONE</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Dorchester, Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>UNKNOWN</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Ida Mae Ballard</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><input type="checkbox"/>  |  | 16. SOCIAL SECURITY NO.<br><input type="checkbox"/>   |  | 17. INFORMANT<br><u>Clarence E. Vaughn Cambridge Md.</u><br>Address   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas</u><br><u>157X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) _____<br>(a), stating the underlying cause last. DUE TO (c) _____  |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 Year</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) _____ (County) _____ (State) _____  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><u>John Mace Jr</u>   |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | DATE SIGNED<br><u>5/13/57</u>   |  |
| EXAMINER'S NAME (Type)<br><u>JOHN MACE JR</u>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Buried</u>  |  | 22b. DATE THEREOF<br><u>5-13-57</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Vaughn Cemetery</u>  |  | 22d. LOCATION (City, town, or county) _____ (State) _____<br><u>CAMBRIDGE Md.</u>                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Leon W. Henry Cambridge Md.</u>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>5/13/57</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>John Mace Jr.</u>  |  |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: *William J. ...*  
 SEX: *M* AGE: *...*  
 DATE OF DEATH: *...*  
 PLACE OF DEATH: *...*  
 OCCASION OF DEATH: *...*  
 CAUSE OF DEATH: *...*  
 MANNER OF DEATH: *...*  
 SIGNATURE OF EXAMINER: *...*  
 OFFICE OF EXAMINER: *...*

NAME OF DECEASED: *William J. ...*  
 SEX: *M* AGE: *...*  
 DATE OF DEATH: *...*  
 PLACE OF DEATH: *...*  
 OCCASION OF DEATH: *...*  
 CAUSE OF DEATH: *...*  
 MANNER OF DEATH: *...*  
 SIGNATURE OF EXAMINER: *...*  
 OFFICE OF EXAMINER: *...*

BUREAU V. 21

MAY 20 1957

RECEIVED

*John Mace Jr*  
*John Mace Jr*  
 X

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5169 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05153

Reg. Dist. No.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Dorchester</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>                              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Seaford Del. R.D.</b>   | c. LENGTH OF STAY IN 1b<br><b>57 yrs</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Seaford Del. R.D.</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |  | d. STREET ADDRESS<br><b>/</b>  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Joseph</b> Middle <b>Hicks</b> Last <b>Wheatley</b>  |  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>17</b> Year <b>1957</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                | 8. DATE OF BIRTH<br><b>12/11/99</b>   |
| 9. AGE (In years last birthday)<br><b>57 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Dorchester, County, Md.</b>                       |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>George E. Hicks Wheatley</b>   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Georgia Ellis</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |   |
| 16. SOCIAL SECURITY NO.<br><b>214-10-0768</b>  |  | 17. INFORMANT<br><b>Lala Wheatley, Seaford, Del.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracranial injury</b><br>835X DUE TO <b>Multiple fractures of skull</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Instant</b> |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Tractor overturned and fell on him.</b>                                 |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>6.30 PM 5/17/1957</b>  | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Field</b>   | 20f. (City or town) (County) (State)<br><b>Seaford R.F.D. Del.</b>                                |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .  |  |  |   |
| ACTUAL SIGNATURE<br><b>John Mace Jr.</b>   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   |
| EXAMINER'S NAME (Type)<br><b>John Mace Jr.</b>   |  | DATE SIGNED<br><b>5/17/57</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>5-21-57</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Firemans</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Sharptown, Maryland</b>                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles W. Mace - Sharptown</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>MAY 22 '57</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Rebecca</b>   |  |  |   |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
5188 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                       |  |                 |  |            |  |                          |  |
|-----------------------|--|-----------------|--|------------|--|--------------------------|--|
| NAME OF DECEASED      |  | SEX             |  | AGE        |  | DATE OF DEATH            |  |
| JAMES EARL RAY        |  | MALE            |  | 37         |  | APRIL 4, 1968            |  |
| PLACE OF DEATH        |  | CITY            |  | STATE      |  | COUNTRY                  |  |
| MEMPHIS, TENNESSEE    |  | MEMPHIS         |  | TENNESSEE  |  | UNITED STATES OF AMERICA |  |
| OCCUPATION            |  | EDUCATION       |  | RELIGION   |  | MARRIAGE                 |  |
| MEMBER OF THE ARMY    |  | HIGH SCHOOL     |  | METHODIST  |  | MARRIED                  |  |
| CAUSE OF DEATH        |  | MANNER OF DEATH |  | TOXICOLOGY |  | ALCOHOL                  |  |
| HEART DISEASE         |  | SUICIDE         |  | NONE       |  | NONE                     |  |
| SIGNATURE OF EXAMINER |  | DATE            |  | TIME       |  | PLACE                    |  |
| JAMES EARL RAY        |  | APRIL 4, 1968   |  | 10:00 AM   |  | MEMPHIS, TENNESSEE       |  |
| SIGNATURE OF WITNESS  |  | DATE            |  | TIME       |  | PLACE                    |  |
| JAMES EARL RAY        |  | APRIL 4, 1968   |  | 10:00 AM   |  | MEMPHIS, TENNESSEE       |  |
| SIGNATURE OF JURY     |  | DATE            |  | TIME       |  | PLACE                    |  |
| JAMES EARL RAY        |  | APRIL 4, 1968   |  | 10:00 AM   |  | MEMPHIS, TENNESSEE       |  |

RECEIVED  
MAY 22 1968  
BUREAU V. 31



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5159 CERTIFICATE OF DEATH

05154

Reg. Dist. No.

|  |                           |   |                                    |  |  |  |   |
|--|---------------------------|---|------------------------------------|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY Dor. Co. MARYLAND   |                           |   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE Md. b. COUNTY Dor. Co. |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Cambridge Md.  |                           |   | c. LENGTH OF STAY IN 1b<br>10 Days |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>x/ Andrews Md. |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Cambridge Md. Hospital  |                           |   |                                    | d. STREET ADDRESS<br>Andrews Md.   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Charles M. Willey  |                           |   |                                    | 4. DATE OF DEATH<br>Month Day Year<br>May 4, 19 57   |  |  |   |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>1881           |  | 9. AGE (In years lost birthday)<br>76 yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----  |                                    | 11. BIRTHPLACE (State or foreign country)<br>Andrews Md.   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 13. FATHER'S NAME<br>Henry E. Willey   |                           |   |                                    | 14. MOTHER'S MAIDEN NAME<br>Sarah E. Willey  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) No   |                           | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br>212-18-6265A   |                                    | 17. INFORMANT<br>Howard Willey   |  | Address<br>Andrews Md.   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial failure<br>422.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-vascular disease. ?<br>DUE TO (c)  |                           |   |                                    |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 day   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>455x Gangrene left foot.  |                           |   |                                    |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                           | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from 4/29/57, 19, to 5/4/57, 19, that I last saw the deceased alive on 5/4/57, 19, and that death occurred at 1 Pm M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) 6 Church St. DATE SIGNED 5/6/57<br>ACTUAL SIGNATURE John Mace Jr. M.D.<br>PHYSICIAN'S NAME (Type) John Mace Jr. Cambridge, Maryland. |                           |   |                                    |  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 22b. DATE THEREOF<br>May 7, 1957  |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br>Sandy Hill   |  | 22d. LOCATION (City, town, or county) (State)<br>Andrews Md.                           |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>LeCompte Funeral Service Cambridge Md.   |                           |   |                                    | 24a. REC'D BY REGISTRAR<br>DATE 5/7/57   |  | 24b. REGISTRAR'S SIGNATURE<br>John Mace Jr.  |   |

CERTIFICATE OF DEATH

|                  |  |                 |  |               |  |                |  |                  |  |                |  |                |  |                |  |                  |  |
|------------------|--|-----------------|--|---------------|--|----------------|--|------------------|--|----------------|--|----------------|--|----------------|--|------------------|--|
| NAME OF DECEASED |  | AGE             |  | SEX           |  | RACE           |  | DATE OF BIRTH    |  | PLACE OF BIRTH |  | CITY OF BIRTH  |  | STATE OF BIRTH |  | COUNTRY OF BIRTH |  |
| JAMES H. HARRIS  |  | 45              |  | M             |  | W              |  | 1912             |  | BALTIMORE      |  | BALTIMORE      |  | MARYLAND       |  | UNITED STATES    |  |
| MARRIED          |  | WIDOW           |  | DIVORCED      |  | SEPARATED      |  | SINGLE           |  | MARRIED        |  | WIDOW          |  | DIVORCED       |  | SEPARATED        |  |
| DATE OF DEATH    |  | PLACE OF DEATH  |  | CITY OF DEATH |  | STATE OF DEATH |  | COUNTRY OF DEATH |  | DATE OF DEATH  |  | PLACE OF DEATH |  | CITY OF DEATH  |  | STATE OF DEATH   |  |
| MAY 10 1957      |  | BALTIMORE       |  | BALTIMORE     |  | MARYLAND       |  | UNITED STATES    |  | MAY 10 1957    |  | BALTIMORE      |  | BALTIMORE      |  | MARYLAND         |  |
| CAUSE OF DEATH   |  | MANNER OF DEATH |  | OCCUPATION    |  | EDUCATION      |  | RELIGION         |  | DATE OF DEATH  |  | PLACE OF DEATH |  | CITY OF DEATH  |  | STATE OF DEATH   |  |
| HEART DISEASE    |  | NATURAL         |  | FARMER        |  | HIGH SCHOOL    |  | METHODIST        |  | MAY 10 1957    |  | BALTIMORE      |  | BALTIMORE      |  | MARYLAND         |  |
| DATE OF DEATH    |  | PLACE OF DEATH  |  | CITY OF DEATH |  | STATE OF DEATH |  | COUNTRY OF DEATH |  | DATE OF DEATH  |  | PLACE OF DEATH |  | CITY OF DEATH  |  | STATE OF DEATH   |  |
| MAY 10 1957      |  | BALTIMORE       |  | BALTIMORE     |  | MARYLAND       |  | UNITED STATES    |  | MAY 10 1957    |  | BALTIMORE      |  | BALTIMORE      |  | MARYLAND         |  |

RECEIVED  
MAY 8 1957  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5170

CERTIFICATE OF DEATH

05155

Reg. Dist. No.

116

|  |                                     |  |   |
|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>DORCHESTER</u> MARYLAND  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>   |                                     | d. STREET ADDRESS <u>404 S. HARRISON ST.</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print) First <u>MARY</u> Middle <u>WILLSON</u> Last <u>WILLSON</u>   |                                     | 4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1957</u>  |   |
| 5. SEX <u>FEMALE</u>   | 6. COLOR OR RACE <u>WHITE</u>       | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCTOBER 13, 1905</u>                              |
| 9. AGE (In years last birthday) <u>51</u> yrs.   |                                     | IF UNDER 1 YEAR IF UNDER 24 HRS.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |                                     | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |   |
| 13. FATHER'S NAME <u>Robert J. Morgan</u>  |                                     | 14. MOTHER'S MAIDEN NAME <u>Minnie Wheeler</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>  |                                     | 16. SOCIAL SECURITY NO. <u>None</u>  |   |
| 17. INFORMANT Address <u>EASTERN SHORE STATE HOSPITAL RECORDS</u>  |                                     |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>LEIOPHEMIA, RIGHT LEG</u><br><u>581.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CIRRHOSIS LIVER</u><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |                                     |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                     |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <u>19</u>  |                                     | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>                                  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>MAY 1</u> , 19 <u>57</u> , to <u>MAY 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 8</u> , 19 <u>57</u> , and that death occurred at <u>3:50 AM</u> , from the causes and on the date stated above.   |                                     |  |   |
| ACTUAL SIGNATURE <u>George E. Currier</u> M.D.   |                                     | ADDRESS (Street, city or town, state) <u>EASTERN SHORE STATE HOSPITAL</u>  |   |
| PHYSICIAN'S NAME (Type) <u>GEORGE E. CURRIER</u>   |                                     | DATE SIGNED <u>CAMBRIDGE, MD.</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF <u>May 10, 57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>  | 22d. LOCATION (City, town, or county) (State) <u>Easton</u> <u>MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. ...</u> ADDRESS <u>Easton MD</u>  |                                     | 24a. REC'D BY REGISTRAR <u>MAY 9 1957</u> 24b. REGISTRAR'S SIGNATURE <u>John Mace, Jr.</u>   |   |

CERTIFICATE OF DEATH

Reg. Div. 104

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>BALTIMORE                    |  | 2. SEX<br>MALE                                     |  |
| 3. RACE<br>WHITE                                  |  | 4. AGE<br>41                                       |  |
| 5. DATE OF DEATH<br>MAY 9 1957                    |  | 6. TIME OF DEATH<br>10:00 AM                       |  |
| 7. CAUSE OF DEATH<br>CORONARY THROMBOSIS          |  | 8. MANNER OF DEATH<br>NATURAL                      |  |
| 9. PLACE OF BIRTH<br>BALTIMORE                    |  | 10. DATE OF BIRTH<br>MAY 18 1916                   |  |
| 11. NAME OF DECEASED<br>JOHN J. BROWN             |  | 12. NAME OF NEXT OF KIN<br>MRS. J. BROWN           |  |
| 13. NAME OF PHYSICIAN<br>DR. J. BROWN             |  | 14. NAME OF BURIAL PLACE<br>CATHOLIC CHURCH        |  |
| 15. NAME OF MINISTER<br>PASTOR J. BROWN           |  | 16. NAME OF FUNERAL HOME<br>ST. ANNE'S             |  |
| 17. NAME OF CEMETERY<br>CATHOLIC CHURCH           |  | 18. NAME OF INTERMENT<br>CATHOLIC CHURCH           |  |
| 19. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 20. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 21. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 22. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 23. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 24. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 25. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 26. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 27. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 28. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 29. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 30. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 31. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 32. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 33. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 34. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 35. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 36. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 37. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 38. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 39. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 40. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 41. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 42. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 43. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 44. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 45. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 46. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 47. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 48. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 49. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 50. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 51. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 52. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 53. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 54. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 55. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 56. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 57. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 58. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 59. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 60. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 61. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 62. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 63. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 64. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 65. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 66. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 67. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 68. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 69. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 70. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 71. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 72. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 73. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 74. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 75. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 76. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 77. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 78. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 79. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 80. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 81. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 82. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 83. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 84. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 85. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 86. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 87. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 88. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 89. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 90. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 91. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 92. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 93. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 94. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 95. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 96. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 97. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 98. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH  |  |
| 99. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  | 100. NAME OF CORPSE OF CEMETERY<br>CATHOLIC CHURCH |  |

BUREAU V. 1

MAY 9 1957

RECEIVED